REPORT OF THE
MANITOBA NURSING REVIEW COMMITTEE
TO THE
MINISTER OF HEALTH

APRIL, 1985

TABLE OF CONTENTS

CHAPTER		PAGES
I	INTRODUCTION	1-6
	Definition of Nursing	
	Terms of Reference	
	Committee Membership	
II	THE ROLE OF LICENSED PRACTICAL NURSES IN THE HEALTH CARE FIELD	7-12
III	JOB DESCRIPTIONS AND REQUIREMENTS	13-16
IV	SUPPLY AND UTILIZATION OF VARIOUS NURSING CATEGORIES	17-26
V	IMPLICATIONS FOR GOVERNMENT	27-28
VI	OTHER ISSUES OF CONCERN	29-33
	Method of Funding	
	Organization of Health Care	
	Career Ladder	
	Direction of Licensed Practical Nurses	
	Operating Room Technicians	
VII	CONCLUSION	34-35
APPENDICES		
I	GLOSSARY OF TERMS	36-42
II	LIST OF SUBMISSIONS RECEIVED BY THE MANITOBA NURSING REVIEW COMMITTEE	43-47
III	SCHEDULE OF PUBLIC MEETINGS	48-50
IV	LEGAL LIMITATION IN MANITOBA UPON REGISTERED NURSES, REGISTERED PSYCHIATRIC NURSES AND LICENSED PRACTICAL NURSES	51-73
V	JOINT STATEMENT ON MEDICAL/NURSING RESPONSIBILITIES ISSUED BY THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA AND THE MANITOBA ASSOCIATION OF REGISTERED NURSES	74-76
VI	HIGHLIGHTS OF THE MANITOBA ASSOCIATION OF REGISTERED NURSES' ENTRY TO PRACTICE REPORT	77-80

CHAPTER I

INTRODUCTION

There are deep differences of opinion among Canadians and among Manitobans about the future direction of the health care delivery system and particularly about the future of nursing. As in so many controversies, genuinely different viewpoints are exacerbated by a failure to agree on the meaning and application of basic terms such as nursing itself.

For some, nursing is an applied science and skill, the principles and practice of which are susceptible of discovery through scientific research and the rigorous application of professional development; for others, nursing embraces all that care which is given to others by prepared persons.

Under this latter viewpoint nursing involves all the care given under the leadership and supervision of directors of nursing service in organized institutional or community settings and includes the work of nurses aides, nursing attendants, and community health nurses but excludes work such as that of physiotherapists, operating room technicians, laboratory workers and so on.

Definition of Nursing

For the purposes of this report, the Manitoba Nursing Review Committee has chosen to define nursing by actor rather than function. Specifically, nursing is comprised of all those individuals certified, licensed or registered to practice by the nursing associations (M.A.R.N., M.A.L.P.N., R.P.N.A.M.). This definition obviously excludes persons not so licensed or registered but performing tasks the same as or similar to some functions performed by nurses. Neither does the definition cover tasks performed by nurses that are normally performed by other groups. Because task assignment is such a blurred and varied area, definition by actor was deemed most efficient. However, comments are offered regarding other groups, for example, nurses aides and operating room technicians.

The Manitoba Nursing Review Committee feels that it is also important to clarify what is meant by community nursing and public health nursing. Community nursing refers to all licensed and registered nurses working in community settings, as opposed to working in acute or chronic facilities. This group includes nurses working for community agencies such as the Victorian Order of Nurses, and nurses working in occupational health settings and in home care. Public health nurses are those nurses employed by public health departments.

For those readers involved in or conversant with health care, the above definition and clarification should be sufficient. A more complete glossary is appended (see Appendix I) for readers not familiar with health care terminology.

Terms of Reference

The Manitoba Nursing Review Committee has been established to deal with some, but only some, of the issues that have arisen out of the ongoing debate in the community about nursing. The formal terms of reference of the Manitoba Nursing Review Committee, established by the Minister of Health in January, 1984 are as follows:

1. Review and comment on the role of the licensed practical nurse in relation to present and future provincial needs.
2. Review and comment on employers' expectations of the licensed practical nurse (as identified in job descriptions) in relation to the present licensed practical nurse educational programs.
3. Review and comment on the supply and utilization of the various nursing categories currently being prepared and employed in relation to the overall present and future provincial needs.
4. Review and comment on the financial implications to Manitoba of the current trends in employment practices of the various categories of nursing personnel.
5. Review and comment on other issues as may be relevant to the study.

Committee Membership

The Committee has held ten public meetings and has considered ninety-nine briefs (See Appendix II for listing) from persons vitally interested in health care. The Manitoba Nursing Review Committee consisted of members with a wide variety of experience. Following is the Committee's membership, along with brief biographical notes and indications of institutional affiliations:

CHAIRMAN

Hon. Mr. Justice Joseph F. O'Sullivan, Winnipeg. Judge, Court of Appeal for Manitoba, Member, Board of Directors St. Boniface General Hospital and Ste. Rose General Hospital.

MEMBERS

Joan Bickford, R.N.,M.S.N., Winnipeg, Chief Public Health Nurse, Manitoba Health. Representative of Manitoba Health.

Lois Britton, B.A., M.A., Ph.D. (a.b.d.), Winnipeg. Director, Programming Branch, Post-Secondary Adult and Continuing Education. Representative of Manitoba Education.

Irene Giesbrecht, R.N., Winnipeg. Executive Director of the Manitoba Organization of Nurses' Associations (MONA). Representative of MONA.

J. C. Gilmour, Winnipeg. Retired Treasurer of the City of Winnipeg. Board Member of: Seven Oaks General Hospital, Blue Cross, Manitoba Medical Services Foundation, Manitoba Health Organizations. Representative of the community at large.

Allan Goldstine, C.A., P. Adm., Winnipeg. Acting Executive Director of the Universities Grants Commission. Representative of the Universities Grants Commission.

Verna Holgate, L.P.N. Winnipeg. Executive Director of the Manitoba Association of Licensed Practical Nurses. Representative of the Manitoba Association of Licensed Practical Nurses.

Zella Mills, R.N., Brandon. Visiting nurse with Home Care, Manitoba Health, Past Chairman of Brandon General Hospital, Member of the Board of Directors of the Manitoba Health Organizations. Representative of the community at large.

Michael Newman, M.D., F.R.C.P.Canada, Winnipeg. Neurologist on staff at the St. Boniface General Hospital and Health Sciences Centre, Past President of the College of Physicians and Surgeons of Manitoba, Associate Professor at the University of Manitoba. Representative of the College of Physicians and Surgeons of Manitoba.

Margaret Redston, R.N., Winnipeg. Standards Officer in the Long Term Care Programs Division, Manitoba Health Services Commission, extensive background in community health nursing. Representative of the Manitoba Health Services Commission

P. J. Ward, R.P.N., B.N., Selkirk. Director of Nursing, Selkirk Mental Health Centre, Chairman of the Registration Examination Committee of the Registered Psychiatric Nurses' Association of Manitoba. Representative of the Registered Psychiatric Nurses' Association of Manitoba.

Bonnie Wright, R.N.,B.A.,B.Sc.N., M.Sc.N., Winnipeg. Assistant Executive Director - Nursing, Victoria General Hospital, prior to this position was a nursing consultant, Ontario Ministry of Labour. Representative of the Manitoba Association of Registered Nurses.

In addition to the above members, Mr. Roy Brown (former Director of the Rural Facilities Division, Manitoba Health Services Commission), Janet Kennedy (former Director of Public Health Nursing, Manitoba) and Mr. Tom Street (Registered Psychiatric Nurses Association of Manitoba) also participated in committee proceedings for a brief period of time.

Barbara Millar, Research and Planning Directorate, Manitoba Health acted as the Recording Secretary for the Committee.

In its deliberations, the Manitoba Nursing Review Committee members have recognized themselves as nominees of interest groups but have tried to bring their own independent perspective to consideration of the material reviewed by the Committee.

In addition to formal briefs and submissions received, the Committee, itself, commissioned studies, sought statistical data and read a wide variety of literature published on the issues addressed to it.

In presenting its report to the Minister of Health, the Manitoba Nursing Review Committee does not purport to present a scientific study but rather the joint recommendations of its members who have been able to agree in the final report without reservation.

MEMBERS OF THE MANITOBA NURSING REVIEW COMMITTEE

J. F. O'Sullivan
Chairman

Verna Holgate

Joan Bickford

Zella Mills

Lois Britton

Michael Newman

Irene Giesbrecht

Margaret Redston

J. C. Gilmour

P. J. Ward

Allan Goldstine

Bonnie Wright

CHAPTER II

THE ROLE OF LICENSED PRACTICAL NURSES IN THE HEALTH CARE FIELD

One of the main reasons for establishing the Manitoba Nursing Review Committee was that complaints were made to the Minister of Health, in particular, and the public, in general, by members of the Manitoba Association of Licensed Practical Nurses. These complaints were particularly strong among licensed practical nurses who have been associated with Brandon General Hospital, the Health Sciences Centre and St. Adolphe Nursing Home. However, there has been a general uneasiness among licensed practical nurses not only in these institutions but in the province as a whole.

The Manitoba Nursing Review Committee listened with concern to complaints by individual licensed practical nurses and groups of licensed practical nurses with charges and counter-charges as to what was said by some nursing administrators on particular occasions. The Manitoba Nursing Review Committee does not consider that it would be productive to pursue particular complaints as to what was said or not said at meetings between nursing directors and licensed practical nurse groups.

The Manitoba Nursing Review Committee as a whole, however, is well satisfied that there has been in some circles, a well articulated and strong attack on the very viability of the occupational group known as licensed practical nurses.

The 1977 Joint Ministerial Task Force on Nursing Education criticized strongly the attempts that were then made by the Manitoba Association of Registered Nurses and others to "phase-in" the Manitoba Association of Licensed Practical Nurses and to abolish the category of licensed practical nurses as a nursing category separately recognized by the legislature of Manitoba. As was then pointed out, the licensed practical nurse does perform a useful and valuable function in the health care delivery system of Manitoba and it is counterproductive to

require licensed practical nurses to justify their status and position every few years.

The Manitoba Nursing Review Committee affirms its confidence that the health care system in Manitoba is well served by the existence of the category of licensed practical nurse. We deplore any attempt to downgrade the status of licensed practical nurses in the health care field. We recognize that in some provinces some of the work of licensed practical nurses is done by registered nursing assistants but we think that Manitoba has gained by having recognized separate categories of nurses; both licensed practical nurses and registered psychiatric nurses. The overwhelming evidence presented to the Manitoba Nursing Review Committee at its private and public hearings confirms that the general public has confidence in licensed practical nurses as "bedside nurses" along with general duty and other registered nurses.

We think it would be wasteful and counterproductive for the category of licensed practical nurse to be downgraded or minimized. We think the overwhelming weight of evidence supports the view that the category of licensed practical nurse quite adequately meets the very important needs of health care recipients in Manitoba. There is not one nursing leader who has suggested that it would be possible to function without an additional category of caregiver. Even those who have proposed that nursing staffs be exclusively of registered nurse qualification inevitably recognized the necessity of having care givers who would not be given the title of "nurse". There is no advantage to health care givers or to health care recipients to have a term like "nurse" reserved exclusively for highly trained, specialized nurses.

Any move toward downgrading licensed practical nurses is likely to have the effect of increasing the numbers of untrained health care providers. Manitobans should consider themselves fortunate in having the category of licensed practical nurse adhering to the long and fine traditions of nursing service and providing cost-effective care to the satisfaction of the recipients of health care.

A number of reasons have been given for a decline in the relative and absolute numbers of licensed practical nurses in Manitoba. Many arguments have been presented to the effect that the increased "acuity" of care requires a higher level of preparation than the licensed practical nurse is able to obtain in the ten or eleven month practical nurse educational programs.

There is no doubt some truth to the claim that, in some settings, increased levels of acuity do require more preparation. However, there was no convincing evidence presented to the Manitoba Nursing Review Committee that suggests that licensed practical nurses are incapable of functioning in a variety of settings including situations where acute care is given. The concept that general hospitals require only registered nurses is not valid in every situation; for example, the plans for the development of nursing staff at Massachusetts General Hospital, one of the world's most renowned acute care hospitals, call for preparation of nurses at the master's level and licensed practical nurse level as the two categories of nursing personnel chiefly employed.

The extent to which registered nurses and/or licensed practical nurses are or are not used, varies among different health care settings. Whereas some acute care facilities function well with a 1:1 registered nurse/licensed practical nurse ratio, others function with a 3:1 ratio. The decision regarding registered nurse/licensed practical nurse staff ratios appears to be made usually by the director of nursing of the facility or sometimes by an outside agency. Factors that influence the decision can be: the acuity of care, funding, global hospital policy and/or professional bias towards registered nurses and against licensed practical nurses.

In those facilities where the ratio of licensed practical nurses to registered nurses has been reduced, it is quite evident that the reasons for making such changes have been either inadequately disclosed or at least not understood by those involved. This has created dissension. While it would be inappropriate to say that all changes in staffing

ratios are based purely on philosophy, or professional prejudice, it is the belief of the Manitoba Nursing Review Committee that these decisions should be made based only on patient need and cost efficiency . As well, great care should be taken to involve affected staff as early as possible and to inform them fully, honestly and as often as necessary to ensure their understanding.

The argument presented before the Manitoba Nursing Review Committee that licensed practical nurses should be limited in their practice to the tasks for which they were specifically prepared in practical nurse educational programs is fallacious. If it were so, this would be the only occupation in which a beginning practitioner would be deemed to have the same qualifications, skills and abilities as an experienced person. We have received a number of submissions which indicated that there has been a deliberate attempt on the part of some registered nurses to classify licensed practical nurses as dead-ended and exit oriented.

We were given one particular example of what was alleged to be the influence of nursing politics in nursing service in the case of the Primary Health Care Unit, Health Sciences Centre. The Unit is similar to doctors' offices where it is common practice to employ licensed practical nurses. Sometime ago, as part of the trend toward exclusive registered nurse staffing, the position of licensed practical nurse was abolished. Yet licensed practical nurses continue to flourish in primary care clinics operated by medical doctors. At the Primary Health Care Unit, Health Sciences Centre, where there are physician directors, there was no need, under existing legislation for licensed practical nurses to be supervised by registered nurses. The presentations, if complete, would indicate that the decision was based not merely on objective criteria but from consideration of nursing policy.

Another problem that has contributed to the decline in opportunities for licensed practical nurses in Manitoba, is the narrowed differential between the licensed practical nurse and registered nurse wage scales. The licensed practical nurses are currently in receipt of approximately

eighty percent of the income of registered nurses (based on comparable years of experience), without taking into account degree differentials. Where the wage differential between licensed practical nurses and registered nurses is not sufficiently wide, there is an incentive on the part of employers to choose the nurse with the "higher" qualifications. The Manitoba Nursing Review Committee asks that the membership of the Manitoba Organization of Nurses' Associations consider this issue in future negotiations.

Directly related to the issues surrounding the role of the licensed practical nurse is the whole question of appropriate educational programs.

It was evident in submissions made to the Manitoba Nursing Review Committee that changes such as rapid technological advances, alterations in health care delivery modes, and a changing nature of patient population are impacting, and will continue to impact on the future roles and relationships between and among categories of nurses. As well, a significant number of submissions from administrative personnel indicated that present educational programs may not prepare licensed practical nurses to meet future nursing service demands.

Given the current trend, the Manitoba Nursing Review Committee suggests that the Manitoba Association of Licensed Practical Nurses, which is charged with the responsibility for maintaining standards, should, in consultation with other appropriate groups, define the role and, hence, the competencies which will be required of future practitioners.

In addition to, and concurrent with, identifying the need to review the basic education program, submissions received from licensed practical nurses repeatedly addressed the need for continuing lateral education which would maintain them within their chosen occupation and also would allow the knowledge and expertise gained, to be recognized, thereby assisting them to adapt to an ever-changing health care delivery system. Further review of job descriptions indicated that continuing education for licensed practical nurses can increase their cost effectiveness,

increasing the overall utilization of this category of nurse while relieving other nursing personnel to assume duties imposed by their own expanding roles.

Therefore, the Manitoba Nursing Review Committee recommends that continuing education programs be designed on the basis of required competencies related to new and increasing demands in health care.

In summary, the Manitoba Nursing Review Committee is of the opinion that the role of the licensed practical nurse has not changed significantly in the health care field in Manitoba. However, there exists the danger that opportunities to exercise that role are being limited by considerations that have little to do with nursing care of the public and nothing to do with prudent use of strained health care funding.

CHAPTER III

JOB DESCRIPTIONS AND REQUIREMENTS

The Manitoba Nursing Review Committee has been asked to comment on employers' expectations of the licensed practical nurse, as identified in job descriptions, in relation to the present practical nurse educational programs.

It was a common theme of many presentations, and the Committee agrees, that nursing schools prepare beginning practitioners. An employer may write a job description for licensed practical nurses which limits them to only a beginning practitioner level. The Committee has already commented on the absurdity of limiting the practice of any occupation to that of a beginning practitioner. The Committee desires, however, to comment on the importance of job descriptions and requirements not only with respect to the licensed practical nurses but also with respect to other groups such as diploma prepared registered nurses, baccalaureate prepared registered nurses, and registered psychiatric nurses.

Job descriptions, briefly and in general, are statements of the scope of responsibilities and/or the functions of the position named. These statements should reflect an expected skill development and professional growth associated with experience in the position. Intimately connected with job descriptions are job qualifications. These indicate the academic qualifications and previous type and length of experience expected of applicants by the facility or agency. It is the articulation between qualifications and scope of position where inconsistencies are evident and potential inefficiencies are found. Where qualifications expected far exceed the responsibilities to be undertaken, the obvious conclusion to be drawn is that cost-efficiency and professional opportunity are being undermined.

One factor in maintaining universality of health care with fair remuneration and working conditions is to use health care personnel appropriately. It is unacceptable that the status of physician should

be required for work that could be done as well, perhaps with medical input, by nurses of one category or another. Similarly, nurse preparation must be taken into account and the educational status required for the position should not exceed the actual requirements of the job to be performed.

In this connection, government has a two-fold responsibility and at times appears to take inconsistent positions. As both the funding body for health care and as the employer of many nurses, government must develop funding policies, standards, job specifications and qualifications that ensure quality and promote cost efficiency in nursing.

A notion has been developed, for instance, that only nurses prepared at the baccalaureate level can be employed in community nursing. Why this is so is not based on any scientific data but on a prejudice that is expressed by persons who say that community health requires baccalaureate preparation. The situation is exacerbated by the tendency to treat all community (health) nursing as if it were public health nursing. The utilization of only baccalaureate nurses in public health and other forms of community nursing, such as home care, suggests that nursing needs are uniform across population groups, thus precluding the need for differential staffing patterns across nursing categories.

There is a need in community nursing, including public health and home care, for nurses who have baccalaureate preparation and indeed masters' preparation. However, to suggest that only baccalaureate prepared nurses can function in these settings is to restrict the expanded and extended roles for nurses so much desired by nursing leaders and so well adapted to the needs of the population. This is particularly so with the current thrusts to extend and expand nursing services in community locations other than hospitals. For instance, in the field of mental health, registered psychiatric nurses function effectively as community mental health workers.

There is no reason why community health services based on nurse clinics without medical protocol, though with medical input, should not be one of the ways in which the public is given access to some form of health care such as diabetes education, health maintenance in the elderly, pre-natal and post-natal care, well baby care and occupational health.

Government, as the funding agent of most health facilities and agencies, either influences or plays a major role in decisions regarding categories of nurses employed and numbers within each category. Standards of staffing, almost without exception, are not regulated by legislation, nor should they be, as flexibility and responsiveness to changing situations are essential. There may be situations, however, where government inadvertently establishes or promotes policies related to staffing categories by approving positions based on largely arbitrary guidelines or facility submissions. Staffing guidelines utilized by the funding body in allocation of staffing dollars must, therefore, be constantly under review to ensure patient needs are met with adequate and appropriate levels of nursing.

The government and the health care industry should be aware of the profound influence that the accreditation (Canadian Council on Hospital Accreditation) process may have on manpower and employment. While participation in this program is formally voluntary, it is a necessity chosen either to maintain medical teaching programs or to acquire some universally accepted recognition within the industry and the community. It is the only statement of worth, so to speak, available to facilities.

The contribution of the Canadian Council on Hospital Accreditation in promoting high standards of health care across the nation is recognized and applauded. However, it is important that accreditation should concentrate on standards rather than the means by which standards are achieved. There is a tendency for accrediting bodies to specify job titles and designations as well as standards. It must be pointed out that those setting the standards for the Canadian Council on Hospital

Accreditation (Canadian Nursing Association, Canadian Medical Association; Canadian Hospital Association; the Royal College of Physicians and Surgeons) do not fund the health care system.

CHAPTER IV

SUPPLY AND UTILIZATION OF VARIOUS NURSING CATEGORIES

The Manitoba Nursing Review Committee has been asked to comment on the categories of nurses that should exist in Manitoba.

Categorized by function, the number of nurses required in the system is large and varied. The Manitoba Nursing Review Committee anticipates that in the foreseeable future, however differentiated nurses may be according to function, there will remain three nursing organizations in Manitoba, namely the Manitoba Association of Registered Nurses, the Manitoba Association of Licensed Practical Nurses and the Registered Psychiatric Nurses Association of Manitoba, each functioning under a separate legislative act.

While the Committee feels confident in recommending that the three existing categories of nurses under these organizations should continue to be prepared and utilized in the delivery of health care, it does not have the means to predict the number that will be required in each category to meet future needs. The Committee encourages government and other health care delivery agencies, including educational facilities, to make use of the Research and Planning Directorate of Manitoba Health in estimating potential supply and demand. It must be recognized that nursing is an occupation in which the supply is extremely flexible. The supply depends not only on the number of nurses prepared but also on those ready to return to the workforce after prolonged periods of absence and on the perceived opportunities that exist for nurses from time to time in various segments of the service setting.

In the view of the Committee, one of the key issues with the categorization of nurses in the future is whether the body known as registered nurses should continue as it presently exists, that is, with no mechanism for recognizing those nurses who are prepared at an advanced level and who have become specialists capable of practising in an extended role.

Nursing is a profession, an applied science and an art, as well as an occupation. The validity of this statement has generated much controversy and discussion both within nursing and external to it. If nursing is ever to gain the general acceptance of its status as a science and a profession, a greater number of highly educated and qualified members who can, in practice, substantiate this claim must be developed. This corps of nursing professionals is required to provide the leadership for the profession in theory, practice, research, education and administration. Without this kind of substantial leadership, general acceptance of nursing as a profession is impossible. This is especially true in Manitoba where so few nurses have had educational opportunities at the master's and doctorate levels.

In addition to the sheer lack of numbers, there is currently no means of recognizing skills and capabilities within a professional association beyond that of registered nurse. The registration process assures the public that each general duty registered nurse has the skills and knowledge to safely render nursing care. In about 80% of the cases, this means at a general duty level in an acute care facility. The registering or licensing association does not rely solely on the diploma, certificate or degree supplied by the educational facility for registration or licensure. Yet, there are no mechanisms established to gain the same assurance regarding those nurses functioning beyond the general duty level. This is analagous to expecting a licensed practical nurse to never function beyond a beginning level. In reality, registered nurses do function well beyond that level. Yet, their only means of proving themselves is through the various diplomas, certificates and degrees from educational facilities.

There is general agreement that there is a need for a body of nurses prepared at an advanced level.

This Committee will not presume to dictate the means for achieving the proper status and recognition due the nursing profession and its individual members. However, it does heartily recommend that the nursing profession, through its associations, find that means for

example, through specialty registers which would include education, administration and research as specialties, or through the development of an identifiable leadership group.

Recently, the Canadian Nurses' Association has proposed that baccalaureate preparation should be the minimum required for entry into practice. The Manitoba Association of Registered Nurses has proposed that a higher level of education, of five to six years duration, will be necessary by the year 2000 for entry into registered nursing practice. In the context of the legislation and reality, this can only mean entry into registered nursing practice.

In the Committee's view, the evidence submitted does not necessarily support the view that for registered nursing practice a baccalaureate degree is today necessary. There are thousands of diploma graduates who are functioning at a high level of proficiency and there is no evidence that the strictly nursing skills of these nurses would be improved by baccalaureate training, rather than by post-basic specialty courses.

The Manitoba Nursing Review Committee, therefore, recommends that the government should not at this time endorse the entry into practice proposals of the Manitoba Association of Registered Nurses. At the same time, the government and the public should, in the opinion of the Committee, recognize the important thrust that lies behind the proposals. These proposals are seen as necessary steps toward the development of an academically prepared nursing cadre and the provision of adequate nursing services to the population. Society can only benefit from such development if the result is not accompanied by downgrading the skills and abilities of those who are already functioning well in the occupation of nursing.

In the opinion of the Committee, the achievement of the aim of nursing leaders requires the assistance of government, particularly in the form of financing university oriented education. However, the Committee thinks it is important to stress the dangers of seeking to find in

legislative enactment a status which can be achieved only in professional development and recognition. An art and science of nursing exists independently of the legislature.

In 1977, the Joint Ministerial Task Force Report on Nursing Education pointed out the difficulties that have arisen in many American states where mandatory practice acts and other legislation have resulted in statutory definitions of nursing or of registered nursing. Unfortunately, such definitions often have in them restrictions on diagnosis, prescription and other areas of practice. Hence, it has been necessary in some jurisdictions for nurses to adopt euphemisms such as assessment, instead of diagnosis, and health planning, instead of prescription.

It was pointed out in 1977 that Manitoba was in a very fortunate position because of the fact that there was no definition of registered nursing in the Manitoba Registered Nurses Act. There was no statutory prohibition against practice of nursing by anyone. It was and is the Medical Act of Manitoba which prohibits unauthorized persons from practicing the so-called "healing art", broadly described to embrace any professional healing art within the limits of nursing.

In the state of the law as it was in 1977, counsel advised that there was no restriction on nursing practice by registered nurses except for those restrictions imposed by common (that is, unwritten) law which essentially says that no person shall hold himself out as having a skill which he does not have. In the absence of statutory restrictions, if a task or work can fairly be called nursing in accordance with nursing tradition (which was and is capable of development) and if it is regarded by a significant body of nurses as nursing, then registered nurses can practice in accordance with the standards set by nursing itself provided they are adequately prepared.

The 1977 Report of the Joint Ministerial Task Force on Nursing Education in Manitoba recommended in strong terms to nursing leaders that it is undesirable to define nursing by statute since every definition is a

delimitation of role. Notwithstanding this advice, the Manitoba Association of Registered Nurses petitioned for and obtained a new Registered Nurses Act in 1980 which does define nursing. Henceforth, as long as this Act is not changed, registered nurses will be limited in their practice by the definition of nursing set out in the Act.

Fortunately, the definition of registered nursing in the 1980 Act is very broad and there may be no practical limitation on the extended and expanded role of nurses. We have obtained a legal opinion from Mr. T. G. Hague, a member of the Department of the Attorney-General, attached in the Appendix IV. Legal counsel says, in his view, the legal limitations on registered nurses are as follows:

"a) The functions undertaken by registered nurses must be consistent with the definition of 'nursing practice' or 'the practice of nursing.' However, since those terms are so broadly defined there is a vast amount of room for the profession of nursing to evolve, thus creating expanded or new roles for registered nurses.

b) If registered nurses are held out as being able to perform certain 'functions' they must have the capacity and skill to perform them. Whether such is the case will depend largely upon their training and qualifications. Accordingly it would be essential to the expansion of nursing into new or expanded roles that proper educational standards and training be developed to ensure that the registered nurses who are to practice in these roles will have the necessary skills and capacity."

He notes the specific authority for the Board of the Manitoba Association of Registered Nurses (subject to the approval of the Lieutenant-Governor-in-Council) to make regulations to develop, establish and maintain standards for the practice of nursing, and so on.

In that sentence, the reference to nursing must, of course, be to registered nursing as defined in the Act. Counsel also notes that the scope of the Registered Nurses Act is not specifically limited by prohibiting registered nurses from carrying out certain functions as diagnosis. Furthermore, there is nothing in the Act which would specifically require registered nurses to be dependent upon or responsible to medical practitioners in carrying out their functions.

This opinion from the Attorney-General's legal counsel is very important. It gives reassurance that the definition of registered nursing contained in the statute is not unduly restrictive.

Since the subject matter is so important to the future of nursing, this Committee asked for a further opinion from a law firm engaged in advising health service agencies. We are grateful for the opinion of Mr. Christian Malburg, confirmed by Mr. E. A. Wehrle, of his firm, given within the constraints imposed by the Attorney-General. Mr. Malburg's opinion letter is also appended to this report (Appendix IV).

It will be seen that second counsel agrees with the first that the definition of nursing practice is so broadly defined in the Registered Nurses Act that there is a vast amount of room for the profession of nursing to evolve, thus creating expanded or new roles for registered nurses. His opinion is even more favourable to the development of nursing in that he indicates that nursing preparation, while essential to good nursing practice, is not a determinant of what nursing practice is. He suggests that nursing practice includes all those functions which are customarily done by nurses or which are accepted by the generality of organized nurses as being nursing functions.

He does, however, repeat the warning that had been given in the 1977 Report of the Joint Ministerial Task Force on Nursing Education in Manitoba to the effect that the definition, broad as it is, is nevertheless confining and need not have been enacted if the purpose of the Act was to give authority to establish, develop and maintain

standards. Standards, as he says, are established within the scope of nursing; the scope of nursing is not determined by the standards.

Moreover, Mr. Wehrle and Mr. Malburg have brought to the Committee's attention the difficulty created for nursing by entering into joint statements on medical/nursing responsibilities. In Appendix V of this report will be found the Statement from the Registrar of the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses.

Statements of this kind may be seen as an indication of goodwill between the two professions but they pose a very serious threat to the development of nursing. This kind of statement will be looked at by a court not merely as an indication between friendly parties of a cooperative relationship; it is likely to be seen as a recognition by nurses of the limitations under which they practice. Just as in statutes, definitions and division of territory set out in such statements are potentially restrictive and delimiting.

It is surprising that nurses who want to fulfill expanded and extended roles, independent of medical protocol where appropriate, should agree that they cannot prescribe appropriate medical treatment unless delegated with supervision. It is true that there is some ambiguity in the term "medical" but in view of the definition of medicine in the Medical Act of Manitoba the statement is capable of being interpreted as recognizing, on the part of registered nurses, that prescription of any medication is beyond their scope unless they are working under the supervision of a medical doctor.

This Committee reemphasizes that it is not in any way seeking to restrict medical practice or to suggest that non-medical people should practice medicine but only that the boundary between medicine and nursing should not be determined by artificial definitions but rather by organic development as each profession, working cooperatively, pursues its line of progress, expanding and extending its role appropriately to meet new and changing conditions.

The ideal of having each health care worker employed appropriately will not be helped by delimiting definitions and artificial division of "turf".

The Committee recognizes that there is a need for well educated nurses prepared with the equivalent of baccalaureate or greater preparation. Therefore, the Manitoba Nursing Review Committee recommends without hesitation that the number of university places in nursing should be increased by having the government, through the Universities Grants Commission, increase the funding available for nursing education programs. The Committee understands that figures previously submitted to the government for a Co-Operative Nursing Program called for a total intake of 75 to 100 full-time students into the first year of the program.

We think that one of the main centres of university education should continue to be the University of Manitoba and we look to the new Director of the Faculty of Nursing to provide leadership at both the undergraduate and post-graduate levels. We see an important continuing role for the University of Manitoba Faculty of Nursing in the development of public health nurses, administrators, teachers and functional categories of all kinds.

The Manitoba Nursing Review Committee was made aware that the University of Manitoba is currently unable to meet the demands of the large number of diploma registered nurses wishing to attain a baccalaureate degree in nursing or of those registered psychiatric nurses wishing to gain access to university based education. In our opinion, the University of Manitoba, Faculty of Nursing has a responsibility to facilitate baccalaureate education for registered nurses via a program that gives significant credit for the academic achievements at the diploma level. Therefore, we strongly recommend that sufficient funding be allocated to meet this need in a manner that would facilitate delivery at the University of Manitoba as well as in other parts of the province.

In order that equal opportunity of access to baccalaureate nursing programs might be shared by northern Manitoba residents, alternative delivery methods should be investigated. There are at present two alternatives that warrant attention. The Universities Grants Commission presently provides grants funding to Inter-Universities North (I.U.N.) for university level programming in northern Manitoba. These programs are given cooperatively by the University of Manitoba, University of Winnipeg and Brandon University. In addition, the government has funded a study on the use of satellite technology to deliver northern programs by the Universities of Brandon and Manitoba. Either of these alternatives may provide a viable solution to distance education for baccalaureate nursing programs.

We see also an importance in establishing a university program in Brandon. We do so on a number of grounds. The nursing profession has not adopted the philosophy that there needs to be general agreement as to conceptual models of nursing education or indeed of conceptual models of nursing practice. It is very important, therefore, that university education in Manitoba should not be limited to, or dominated by one model to the exclusion of others. We think that the University of Manitoba program is best established as a generic program and it is not likely that a professional format can be developed (in the sense that professional has been used in this report) without a generic program where the first years are concentrated in basic sciences and the latter years in nursing theory and practice.

The University of Brandon has demonstrated that there is a perceived need, in the community at large, for registered nurses and registered psychiatric nurses with diplomas to be able to complete a baccalaureate degree in nursing while receiving full credits for the nursing parts of the courses they have taken. We are, therefore, prepared to recommend that the Universities Grants Commission should fund a separate baccalaureate degree program in nursing at Brandon University with emphasis on the conversion of a diploma attainment to baccalaureate attainment.

In so far as the University of Winnipeg is concerned, there was no proposal submitted to the Manitoba Nursing Review Committee and that is not surprising in the sense that the Committee was not specifically appointed to deal with university programs in isolation. If the government rejects the idea that all nurses should be baccalaureate prepared by the year 2000, it would seem that a nursing program at the University of Winnipeg would be unnecessary.

During the course of the hearings before the Committee, proposals were made by St. Boniface General Hospital to the formation of Youville College, which would be affiliated with a Manitoba university and which would combine the senior division, practice and theory based on the unification model. The Committee believes that the suggestions should be followed up and, if it is possible to do so, the program should be added to the educational opportunities that are available for nursing students in the province.

The three associations of organized nurses appear to be functioning well and there have been no suggestions that any legislative changes are needed in any of them: the Manitoba Association of Licensed Practical Nurses, the Registered Psychiatric Nurses Association and the Manitoba Association of Registered Nurses.

This Committee has already said it does not presume to dictate the means for achieving the proper status and recognition due the nursing profession and its individual members. We do suggest, however, that nursing leaders may want to consider whether it might be desirable to establish an organized group of nurses who have attained academic standing and a high level of professional recognition. Such a group might be organized within or outside of the registered nursing association on a voluntary or legislated basis. This Committee points out that, while the initiative should come from nurses themselves, the public as a whole has an important interest in the development of nurses who are professionally able to fulfill an expanded and extended role as members of the nursing profession.

CHAPTER V

IMPLICATIONS FOR GOVERNMENT

It is evident that nursing practice and nursing education are both likely to change in the next several years and such changes will involve government's organizational leadership as well as financial resources. For instance, any substantial increase in the number of university prepared nurses is very likely to result in a decrease in the number of diploma schools. Where such closures should be made and how they should be brought about will be a matter of serious concern to any government.

It is important to see that the supply of nurses or health care workers, under whatever name, is not purely a matter for the three organized nursing groups; the Manitoba Association of Registered Nurses, the Registered Psychiatric Nurses' Association of Manitoba and the Manitoba Association of Licensed Practical Nurses. It is the function of health care agencies and of government, as well as of nursing associations, to ensure that adequate health care personnel are trained and available. If organized nursing, in collaboration with other agencies, is not able to provide such health care workers at reasonable costs, then other means are likely to be taken to educate and prepare them.

One of the great problems with effecting needed changes is that there is no on-going forum for leaders to join together with a view to establishing and maintaining such changes. In the 1977 Report of the Joint Ministerial Task Force on Nursing Education in Manitoba proposals were made to have a Council of Nursing Education established but this did not receive general approval. In fact, the gap between nursing associations and between educational facilities has increased rather than decreased since that time. There is no automatic assurance that persons of different viewpoints will merge into a common effort to achieve broad results but the existence of a suitable meeting ground would enhance the prospect. If decisions are to be made, in accordance with the best interests of the common good, it is important that so called purely politicial consideration should not be predominant.

The Manitoba Nursing Review Committee is of the opinion that it would be valuable to establish a Council on Nursing Education and Practice. This Council should be given an advisory role to governments, educational authorities, nursing organizations and health providers and should be a means of promoting the dialogue necessary in the development of nursing.

The Council on Nursing Education and Practice should consist entirely of appointees of government nominated by various groups with broad representation, similar to the Manitoba Nursing Review Committee, including practitioners, educators and providers of health care. The Council should have full access to and right to make use of the facilities of the Research and Planning Directorate, Manitoba Health. While government should not be bound to follow the advice of the Council, nevertheless, it should be required to consult with the Council before making major decisions with respect to government's role in the provision of nursing care.

CHAPTER VI

OTHER ISSUES OF CONCERN

1. Method of Funding

A great deal is written about the desirability of funding nursing education and preparation through Manitoba Health, or other more educationally oriented departments. The Manitoba Nursing Review Committee is satisfied that Manitoba Health will have to be involved in nursing education to a very large degree. A good deal of education will, of necessity, be clinical in nature and service related and must take place in practice settings where it is impractical to segregate, rigidly, service costs and educational costs.

Whether the bulk of financing for education comes from one department of government or another will largely depend on the kind of cost-sharing arrangements that can be made with the Government of Canada and with other provincial governments. In deciding upon a formula for financing, the Committee cautions against excessive reliance on United States' arguments which are frequently based on quite different payment mechanisms.

Related to this issue is the question of where on-the-job training should take place. There is general agreement that the educational programs prepare beginning practitioners and that there is a period of time following graduation when graduates might benefit from a period of internship or other such practical preparation. Whether such practical preparation should best take place in the educational setting or in the practice setting will largely be dependent on the financing most readily available. All of the members of the Manitoba Nursing Review Committee would deplore any return to situations where students are regarded as a source of cheap labour during the period of their practical education.

2. Organization of Health Care

It is not the function of the Manitoba Nursing Review Committee to review in any depth the organization of the health care system but what the Committee has to say requires some awareness of how the system is designed to function.

Medical care, in Manitoba, is entrusted entirely to licensed physicians and surgeons, who function under the Medical Act which is designed to protect the public as well as the members of the profession. A very large number of the other health care providers are working in not-for-profit agencies, whether owned by the province, local governments, religious organizations or voluntary groups. The relationship between the Manitoba Health Services Commission and these health care agencies is one that requires cooperation and collaboration. The Manitoba Health Services Commission acts not only as a purchaser of services on behalf of persons covered by health insurance but also as a medium designed to make available to Manitobans, on an equitable basis, the resources that Manitoba requires for adequate health care.

Most health care agencies are operated by boards of directors with accountability for the agencies' activities. The boards invariably delegate authority to chief executive officers and other managers but the responsibility and accountability remain with the boards of directors or those who appoint the boards.

So far as nursing structure is concerned, the Manitoba Nursing Review Committee recommends that the line of authority and communication must be clearly stated and that authority must be delegated with suitable accountability.

The Manitoba Nursing Review Committee was struck by the number of instances when members of the board of directors of health care facilities and even chief executive officers did not appear to be alert to the implications of decisions made by directors of nursing.

In some instances, it appears that decisions by nursing directors are influenced more by considerations of nursing organization and hierarchical structure than they are by the mission, aims and objectives of each agency. However, we saw no evidence, whatsoever, of any organized conspiracy among nursing directors to have one form of organization prevail over another. Rather, it is a question of a continual search for the best form of nursing organization that moves nursing structures from functional nursing through team nursing through primary nursing. The Manitoba Nursing Review Committee applauds the spirit which enables such experimentation and improvement to go on but the Committee cautions that senior nursing executives should bring change in operational structure to the attention of the respective boards of directors so that they will appreciate the implications as to cost as well as to personnel policy and patient care.

3. Career Ladder

A great deal of attention has been given over the last twenty years to the career ladder concept in nursing education. The 1977 Report of the Joint Ministerial Task Force on Nursing Education in Manitoba encouraged experimentation with the career ladder concept. The Manitoba Nursing Review Committee is also of the view that the career ladder is a worthwhile concept, in so far as it provides opportunities for nurses to gain credit for what they have already learned. However, the Committee cautions against an uncritical adoption of the career ladder concept since it has been well established that the formation of nurses and, in particular, the formation of professional nurses is not simply a matter of adding knowledge to knowledge.

Indeed, we urge that the proposed Council on Nursing Education and Practice should undertake, as one of its first tasks, a review of the concept of integrating practical nurse education and diploma nursing education and also of nursing programs at Red River Community College.

In connection with the concerns that have been expressed to the Committee as to why such a large number of licensed practical nurses opt to take diploma nursing, a recent study to explore this very issue, was undertaken by the Programming Branch, Manitoba Education in conjunction with the Manitoba Association of Licensed Practical Nurses. The conclusion from the data is that licensed practical nurses are uncertain about the future of licensed practical nursing.

The Committee believes it is important that licensed practical nurses continue to be an integral part of the health care system. It is incumbent on the Manitoba Association of Licensed Practical Nurses, as well as others, to allay the fears about the future of licensed practical nurses and future graduates by clearly defining the role of the practical nurse.

The Committee reemphasizes the importance of maintaining adequate numbers of licensed practical nurses for the needs of the health care system. Therefore, licensed practical nurses should be able to make satisfactory careers with their basic preparation and continuing education without having to, or being expected to, change their status.

4. Direction of Licensed Practical Nurses

Prior to the legislative change in 1980, licensed practical nurses were required to work under supervision; that is, with an overseer physically present. Since 1980, licenced practical nurses are required to function under the direction of a registered nurse or physician. The word direction allows more independence of function because direction can be given in writing, by telephone, etc. Therefore, the argument that licensed practical nurses are more expensive to hire than they seem because of add-on supervisory costs is no longer necessarily true. Today, the only legitimate add-on cost exists in settings where, frequently, the patients require interventions beyond the scope of the licensed practical

nurse's practice. These add-on costs for a registered nurse are basically task related. The extent of these costs, in conjunction with the funding available to any particular service unit, should determine the cost efficiency of the staffing ratio. From evidence submitted to the Committee, given the legislative change in 1980, it would appear that in most instances, a registered nurse/licensed practical nurse mix is more cost efficient than an all registered nurse staffing.

5. Operating Room Technicians

Submissions relating to operating room technicians were also received by the Manitoba Nursing Review Committee. Their knowledge and training are specific to the operating room and their expertise in the area is valued by surgeons and co-workers alike. The operating room technician's salary is comparable to that of a licensed practical nurse.

In our opinion, the operating room technicians provide cost effective, highly skilled technical care in operating rooms and, therefore, we recommend that this category of worker should be encouraged and maintained through continuance of their training program and through continued employment opportunities.

CHAPTER VII

CONCLUSION

Since its inception in January, 1984, the Manitoba Nursing Review Committee has listened to, studied and struggled with the issues facing nursing and health care today and in the foreseeable future. After acquiring some notion of the broad scope of issues that could have been dealt with, the first important task was to narrow that scope to a manageable one. It was not the intention of this Committee to make all possible recommendations for every issue. Instead, it was deemed prudent to select only those issues of a highest and most urgent priority. Along with making recommendations, the Committee also made suggestions for establishing a mechanism whereby future issues could be dealt with more easily, preferably prospectively.

From the outset, it was realized that the recommendations and suggestions of this Committee would not please all readers of the report. The Committee has attempted to formulate an honest, factual, practical report based on the consensus reached by the Committee members. The simple fact of this diverse group of individuals being able to reach a consensus indicates a great deal of hope that, in fact, the groups they represent will be able to do likewise and to make possible the implementation of the recommendations and suggestions in this report. The Committee makes no apology for areas of compromise for that is the way in which true progress is made.

In this report, the Committee has confirmed the valuable role of all existing categories of nurses. Whereas the settings and roles for nurses may change or expand as the future unfolds, the province cannot dispense with any group if it is to continue to provide the best possible care at an affordable price. Health care facilities and agencies as well as professional and licencing bodies must prepare for the future needs of the population through adequate preparation of health care providers together with innovative, cost-effective delivery systems where all actors can play an appropriate part.

Specifically, regarding the preparation of nursing and nurses for the future, there need to be developed programs which produce greater numbers of nursing leaders at a high level of preparation along with a mechanism(s) for the recognition of such expertise. Also, the inevitable increases in knowledge and technology will demand changes in initial preparation as well as the opportunity to specialize in various clinical areas. To this end, several recommendations were made regarding nursing education, professional recognition and professional development.

Obviously, one of the most important and difficult issues is health care planning. This must be global and long term. Health care planning will demand cooperation and collaboration of all groups involved including: government, organizations of health care providers, employers of these providers, educational facilities and the public. The Committee emphasizes and encourages this effort by suggesting there be an official forum established for this kind of cooperation and collaboration to occur.

The Committee members trust that this report will be accepted for its intent to be a productive beginning for future change that will be accomplished by others. There are many suggestions and recommendations in the report which, when implemented, will result in an improved health care system.

The future will unfold. The choice is to anticipate it and prepare or ignore it and react to its demands after the fact. Either has costs and consequences. Therefore, the choice must be made honestly and with serious deliberation.

APPENDIX I

GLOSSARY OF TERMS

GLOSSARY OF TERMS

Accreditation:

- is a voluntary process of measuring the degree to which specified standards have been met and the formal recognition thereof.

Applied Science:

- is a body of knowledge, developed through rigorous scientific process, ascribed to a particular discipline and finding expression in practice.

Art:

- is the talent to add a non-scientific dimension to the practical aspect of an applied science.

Baccalaureate Prepared Nurse:

- see Types of Nurses

Beginning Practitioner:

- is an individual meeting the minimum requirements for certification, licensure or registration such that he/she is safe to practice and has sufficient skills to enter the occupation. It is assumed that, over time and with experience, these skills will be further developed, refined and expanded.

C.C.H.A.:

- Canadian Council on Hospital Accreditation, the body conducting the accreditation process for health care facilities, long term facilities and mental health facilities in Canada.

C.H.A.:

- Canadian Hospitals Association, the national body formed to deal with global facility issues in Canada made up of representatives of the provincial hospital associations.

C.M.A.:

- Canadian Medical Association.

C.N.A.:

- Canadian Nurses Association.

Community Health Nurse:

- a nurse whose practice setting is not in acute or chronic care facilities, but is in community settings such as occupational health, home care, public health agencies.

Community Mental Health Worker:

- a professional (example, R.P.N.) who provides a comprehensive range of mental health services including assessment, treatment and consultation, within a community setting.

Diploma Prepared Nurse:

- see Types of Nurses

D.O.N. - Director of Nursing

- is a highly qualified nurse charged with the responsibility of planning, organizing, leading, controlling and evaluating the nursing services within a facility or agency. This position may be designated by other titles, for example, vice president, assistant executive director, etc.

Doctoral Prepared Nurse:

- see Types of Nurses

Entry to Practice:

- is the minimum qualification required for certification, licensure or registration as a beginning practitioner.

General Duty Nurse:

- see Types of Nurses

Health Care Delivery System:

- is the totality of facilities, agencies, programs and personnel which provide services to the population regarding the promotion, maintenance and restoration of health and prevention of illness.

Health Care Workers/Providers:

- are all actors in the health care delivery system.

L.P.N. - Licenced Practical Nurse:

- see Types of Nurses

M.A.L.P.N.:

- is the Manitoba Association of Licensed Practical Nurses.

M.A.R.N.:

- is the Manitoba Association of Registered Nurses.

Masters Prepared Nurse:

- see Types of Nurses

M.O.N.A. - Manitoba Organization of Nurses Associations:

- is the union engaged in negotiating collective agreements and monitoring the working conditions of its members. Membership includes registered nurses, licensed practical nurses, registered psychiatric nurses and operating room technicians.

Nursing Administrators:

- are qualified nurses employed as middle or senior nurse managers within an organization.

Nursing Attendants/Aides:

- see Types of Nurses

Nursing Practice:

- is the functional scope of certified, licensed or registered nurses.

Nursing Service:

- is the organization of nurses within a facility or agency to facilitate the delivery of patient care and the achievement of organizational or agency objectives.

Occupation:

- is a set of productive, related tasks undertaken to earn a living.

O.R.T. - Operating Room Technician:

- is an individual with special and specific training to work in an operating room.

Profession:

- is a discrete discipline meeting specific criteria, for example, self regulation and discipline based on a scientifically derived knowledge base.

Public Health Nurse:

- is a duly certified, licenced or registered nurse employed by a public health department or agency.

R.N.A. - Registered Nursing Assistant:

- is an individual licenced by an appropriate body to practice as an R.N.A. in other provinces. R.N.A.'s perform functions similar to Manitoba's L.P.N.'s but of a lesser scope.

R.N. - Registered Nurse:

- see Types of Nurses

R.P.N.A.M.:

- Registered Psychiatric Nurses Association of Manitoba.

Types of Care:

- Preventative:
  those interventions designed to avoid the risk or occurrence of disease or health problems.

- Primary:
  those interventions designed to identify the risk or presence of disease or health problems prior to the loss of optimal health or function.
- Secondary:
  those interventions designed to arrest and reverse the effects of an acute episode of a disease or health problem.
- Tertiary:
  those interventions designed to minimize or reverse to an optimal degree the chronic effects resulting from a disease or health problem.

Types of Nurses:

- Doctoral prepared nurses are nurses holding a Ph.D. degree. There are no doctoral programs in nursing in Canada at this time. Such degrees are either non-nursing or non-Canadian.
- Master's prepared nurses are nurses holding a Master's degree. These degrees, if in nursing, are usually granted in a clinical specialty, administration or education. Degrees are also obtained in related disciplines such as Health Administration, Education, etc.
- Baccalaureate prepared nurses are nurses holding a Bachelor's degree in nursing. In many instances, this refers specifically to people who have chosen to obtain their degree as their initial nursing education before entering practice.
- Graduate nurses are nurses who have successfully completed a certificate, diploma or degree in nursing but who may not be registered.
- L.P.N. is an individual licenced by M.A.L.P.N. to practice.
- R.N. is an individual registered by M.A.R.N. to practice.
- R.P.N. is an individual registered by R.P.N.A.M. to practice.
- Nursing Attendant/Aide is an individual prepared to some degree to perform designated functions within a nursing unit but not certified, licenced or registered to practice nursing.
- General duty nurse is a nurse who practices basically at the hospital bedside.

APPENDIX II

LIST OF SUBMISSIONS RECEIVED
BY THE
MANITOBA NURSING REVIEW COMMITTEE

Submissions are listed in the order in which they were received.

Submission Number	Received from
1	R. Webster, Winnipeg
2	C. Thibeault, Winnipeg
3	B. Ring, Brandon
4	Mrs. J. H. Peterson, Dominion City
5	B. Schaeffer, Brandon
6	W. Kartanson, Minnedosa
7	G. Baker, Minnedosa
8	K. Elzer, Winnipeg
9	M. Elzer, Winnipeg
10	Dr. B. Postl, Northern Medical Unit, University of Manitoba
11	Mrs. Wilks, Winnipeg
12	L. Nolette, S. Ernest, C. Kreitz, G. Dumont, I. Koehler, G. Mason, K. Bremaud (St. Adolphe Nursing Home)
13	W. S. Patmore, Exec. Director, The Pas Health Complex
14	Mrs. Searle, Minnedosa
15	N. B. Gerardin, Thorne, Stevenson & Kellogg, Winnipeg
16	N. Cass, R.N., Winnipeg
17	Dauphin Chapter of The Manitoba Association of Licensed Practical Nurses
18(a)	Rick and Roberta Cliche, Winnipeg
18(b)	Roberta Cliche, Winnipeg
19	K. Riley, Minnedosa (includes a petition with 306 signatures)
20	E. Major, Ile des Chenes
21	Alumnae of St. Boniface L.P.N. School
22	Petition from Altona (13 signatures)
23	B. Wood, Brandon
24	R. and B. Montgomery, Wawanesa
25	Westman Chapter of Licensed Practical Nurses
26	V. Dobson, Winnipeg

27	Group of nurses (13 signatures), Primary Health Care Unit, Health Sciences Centre
28	Manitoba Paramedical Association
29	G. Elzer, Winnipeg
30	C. Fawcett, Brandon
31	D. Gerrie, Chairman of the Board, Winnipeg Municipal Hospital
32	Committee of Concerned L.P.N.s, Health Sciences Centre
33	Petition (27 signatures), Winnipeg
34	C.R. Both, Winnipeg
35	Dauphin Medical Group
36	J. Purdie, Brandon
37	Manitoba Medical Association
38	Chapter #3 Concerns Committee, District 1 The Pas, Manitoba Association of Licensed Practical Nurses
39	Petition (68 signatures), Winnipeg
40	Board of Directors, Souris Hospital District #11
41	L.P.N.s at Children's Centre, Health Sciences Centre
42	M. Robinson, President, Manitoba Nursing Administration Interest Group
43	J. T. Ellis, Chairman of the Board, Victoria General Hospital
44	Staff Members, Children's Centre, Health Sciences Centre (84 signatures)
45	R. Clarke, Nurses for Life Interest Group
46	Manitoba Organization of Nurses' Associations
47	Nursing Education, Assiniboine Community College
48	D. Hrymack, Director of Nursing, McCreary/Alonsa Health Centre
49	Manitoba Community Nurses' Interest Group
50	Nursing Department, Red River Community College
51	Keewatin Community College
52	Board of Grace General Hospital
53	E. Baudin, Director of Patient Care, Swan River Valley Hospital

54	Licensed Practical Nurses (23 signatures) at Morden General Hospital
55(a)	Seven Oaks General Hospital Department of Nursing
55(b)	Board, Seven Oaks General Hospital
56	Registered Psychiatric Nurses' Association of Manitoba
57	Manitoba Enterostomal Therapist Interest Group
58	J. Kellie, Portage la Prairie
59	Board of Directors, Brandon General Hospital
60	Winnipeg Chapter of the Manitoba Association of Licensed Practical Nurses
61	Manitoba Association of Cardiology Technologists
62	Manitoba Association of Registered Nurses
63	Health Sciences Centre Position Paper on the Changing Role of the L.P.N.
64	Health Sciences Centre, School of Nursing
65	D. Kilburn, Neepawa
66	S. Jacobson, Flin Flon
67	P. Derkatch, Vice-President, MONA, Local 14, Flin Flon
68	G. Steuart, Acting Director of Nursing, Flin Flon General Hospital
69	Senior Nursing Administration: Brandon Mental Health Centre, Manitoba School (Portage la Prairie) Selkirk Mental Health Centre
70	Manitoba Association of Licensed Practical Nurses
71	A brief in Response to a Paper of Concern to the Board of Directors of the Brandon General Hospital by Licensed Practical Nurses Employed at the Brandon General Hospital from Nursing Administration
72	Winnipeg Association of Critical Care Nurses
73	L. Sharp, Winnipeg
74	Dr. H. Chochinov, Honorary Chairman of the Operating Room Technician of Manitoba Association
75	The Manitoba Association of Registered Nurses' Entry to Practice Report
76	College of Physicians and Surgeons of Manitoba

77	F. Racher, Souris
78(a)	Brandon University, Independent Nursing Program
78(b)	Brandon University, Cooperative Nursing Program
79	B. Clark, Brandon
80	L. Robbins, Brandon
81	E. DeCock, Brandon
82	L. Clark, Brandon
83	Manitoba Association of Registered Nurses - Westman Region
84	St. Boniface General Hospital
85	Manitoba Health Organizations Incorporated
86	Grey Nuns of Manitoba
87	R. Rossier, Winnipeg
88	University of Manitoba Faculty of Nursing
89	J. Larsen, Director (as of July 1, 1985), Faculty of Nursing , University of Manitoba
90	N. Laferriere, Selkirk
91	P. MacKenzie, Winnipeg
92	K. Chorney, President, Manitoba Association of Licensed Practical Nurses, Selkirk Chapter
93	B. Zegarac, Brandon
94	J. Bouchard, Ste. Rose du Lac
95	K. Emberley, Winnipeg
96	A. Zeiler, Winnipeg (verbal submission)
97	R. Clague, Winnipeg (verbal submission)
98	D. Breed, Winnipeg (verbal submission)
99	Post-Secondary, Adult Continuing Education (Programming Branch, Department of Education) and the M.A.L.P.N. - "A study to determine why practical nurse students and licensed practical nurses change their career aspirations and pursue registered nursing at Red River Community College."

APPENDIX III

SCHEDULE OF PUBLIC MEETINGS

SCHEDULE OF PUBLIC MEETINGS

1. May 10, 1984 - Winnipeg - Presentations by:
   1.1 Mrs. Eva Major, Ile des Chenes
2. May 17, 1984 - Winnipeg - Presentations by:
   2.1 L.P.N.s employed at St. Adolphe Nursing Home represented by L. Nolette
3. June 8, 1984 - Winnipeg - Presentations by:
   3.1 Manitoba Association of Registered Nurses represented by Ms. M. Deegan, President, M.A.R.N.
   3.2 Manitoba Organization of Nurses' Associations represented by V. Chernecki (President), P. Miller (1st Vice-President) and D. Brown (2nd Vice-President)
   3.3 Board of Grace General Hospital represented by B. Yallowega, Assistant Administrator and Major D. Perry
   3.4 Board of the Brandon General Hospital represented by Miss M. Bicknell, Assistant Executive Director - Patient Services, Miss J. MacKay, Director of Nursing Services and Mrs. S. J. Paine, Director of Nursing Education.
4. June 21, 1984 - Winnipeg - Presentations by:
   4.1 Operating Room Technicians' Association represented by C. Both (President)
   4.2 Community Nurses' Interest Group represented by Mrs. C. Belanger
   4.3 Mr. L. Gorski, Director, Residential Care Division, Department of Community Services and Corrections
5. June 22, 1984 - Winnipeg - Presentations by:
   5.1 Manitoba Association of Licensed Practical Nurses represented by C. Houle (President), P. Van Woensel, D. Cherpako, B. Latimer, M. Babos and R. Jacuk
   5.2 Board of Directors of Souris Hospital District #11 represented by Mrs. S. Lyon, Trustee, Mrs. Kloon (Director of Nurses) and Mrs. C. Reynolds
6. September 6, 1984 - Brandon - Presentations by:
   6.1 Registered Psychiatric Nurses' Association represented by Mrs. Fitzsimmons (President)

6.2 F. Racher

6.3 J. Lewis, Assiniboine Community College

6.4 Brandon University represented by Dr. R. Giles and Dr. P. Letkeman

6.5 Manitoba Association of Registered Nurses - Westman Region represented by Mr. A. Pattison (Acting President)

7. September 7, 1984 - Brandon - Presentations by:

7.1 Westman Chapter of the Manitoba Association of Licensed Practical Nurses

8. September 14, 1984 - Winnipeg - Presentation by:

8.1 Presentation on the M.A.R.N. Entry to Practice Report given by the M.A.R.N. Ad Hoc Entry to Practice Committee

8.2 Manitoba Health Organizations represented by Mrs. J. Ramage and Mrs. Shirley Seidel.

9. September 27, 1984 - Winnipeg - Presentations by:

9.1 St. Boniface General Hospital represented by Mr. Quaglia (President), Ms. J. Dick (Vice-President, Nursing) and Ms. J. Greenwood (Director, Special Nursing Projects)

9.2 College of Physicians and Surgeons of Manitoba represented by Dr. F. P. Doyle and Dr. K. Brown

9.3 University of Manitoba Faculty of Nursing represented by: Prof. N. Peters (Acting Director), Dr. J. Larsen (Director as of July 1, 1985) and Dr. T. Hogan (Associate Vice-President).

10. September 28, 1984 - Winnipeg - Presentations by:

10.1 Red River Community College represented by Ms. B. Barnard and Ms. J. Burrows

10.2 K. Emberley

10.3 A. Zeiler

10.4 R. Clague

10.5 D. Breed

APPENDIX IV

LEGAL OPINION - LEGAL LIMITATION IN MANITOBA UPON REGISTERED NURSES, REGISTERED PSYCHIATRIC NURSES AND LICENSED PRACTICAL NURSES

MANITOBA
DEPARTMENT OF THE ATTORNEY-GENERAL
Civil Litigation
Telephone 945-2877
6th Floor, Woodsworth Building
405 Broadway Avenue
Winnipeg, Manitoba, Canada
R3C 3L6

October 22, 1984

File No. 748
in reply please refer to
T. G. Hague

The Honourable Mr. Justice
J. F. O'Sullivan
Court of Appeal
310 Law Courts Building
Broadway at Kennedy Street
WINNIPEG, Manitoba
R3C OV8

My Lord:

RE: LEGAL OPINION - LEGAL LIMITATIONS IN MANITOBA UPON REGISTERED NURSES, REGISTERED PSYCHIATRIC NURSES, AND LICENCED PRACTICAL NURSES

The following constitutes the opinion you have requested regarding the legal limitations existing in Manitoba upon registered nurses, registered psychiatric nurses, and licenced practical nurses.

Legal Limitations on Registered Nurses:

Nurses "acting within the scope of The Registered Nurses Act" are exempt by virtue of subsection 2(2) of The Medical Act, from the prohibition on persons practicing medicine without a licence, contained in that Act.

A nurse, duly registered under The Registered Nurses Act, and named in the roster as an active practicing member, is entitled by virtue of subsection 10(1) "to practice as a registered nurse in Manitoba and, subject to any restrictions imposed by any by-law of the association, is entitled to hold herself out as a registered nurse".

The definition of the terms "nursing practice" or "the practice of nursing" in clause 1(g) of The Registered Nurses Act indicates the scope of that Act, within which a registered nurse may practice without coming into conflict with the prohibition

against practicing medicine without a licence contained in subsection 2(2) of The Medical Act.

As defined, the terms "nursing practice" or "the practice of nursing" do not delineate a clearly marked boundary limiting the scope of The Registered Nurses Act. Instead, they describe in a general way the authorized role of a registered nurse in the health care system.

In my view, the legal limitations on registered nurses are as follows:

a) The "functions" undertaken by registered nurses must be consistent with the definition of "nursing practice" or "the practice of nursing". However, since those terms are so broadly defined, there is a vast amount of room for the profession of nursing to evolve, thus creating expanded or new roles for registered nurses.

b) If registered nurses are held out as being able to perform certain "functions" they must have the capacity and skill to perform them. Whether such is the case will depend largely upon their training and qualifications. Accordingly, it would be essential to the expansion of nursing into new or expanded roles that proper educational standards and training be developed to ensure that the registered nurses who are to practice in these roles will have the necessary skills and capacity. In that regard, I note there is specific authority contained in subsection 5(1) for the board of the Manitoba Association of Registered Nurses (subject to the approval of the Lieutenant-Governor-in-Council) to make regulations to:

> (c) develop, establish and maintain standards for the practice of nursing;
>
> (d) develop, establish and maintain standards for nursing education consistent with the changing needs of society;
>
> (e) define by education, experience or otherwise, general or specialized areas in nursing;

It is important to note that the scope of The Registered Nurses Act is not specifically limited by prohibiting registered nurses from carrying out certain functions such as diagnosis. Furthermore, there is nothing in the Act which would specifically require registered nurses to be dependent upon or responsible to medical practitioners in carrying out their functions. Rather, the terms "nursing practice" or "the practice of nursing" refer to nurses carrying out functions "directly or indirectly in collaboration with a client and other health workers".

Psychiatric Nurses - Legal Limitations:

Subsection 2(2) of The Medical Act exempts from the prohibition contained in that Act against persons practicing medicine without a licence, "a nurse acting within the scope of ... The Psychiatric Nurses Association Act" (now repealed and replaced with The Registered Psychiatric Nurses Act).

A nurse duly registered under The Registered Psychiatric Nurses Act whose name appears on the roster of active practicing members is by virtue of subsection 11(1) "entitled to practice as a psychiatric nurse in Manitoba and, subject to any restrictions imposed by any by-law of the association, is entitled to hold herself out as a registered psychiatric nurse".

The definition of the terms "psychiatric nursing" or "the practice of nursing" in clause 1(g)
of The Registered Psychiatric Nurses Act sets out the scope of that Act, within which a registered psychiatric nurse may practice without coming into conflict with the prohibition against practicing medicine without a licence contained in subsection 2(2) of The Medical Act. The approach taken in this Act is similar to that taken in The Registered Nurses Act in the sense that the terms "psychiatric nursing" or "the practice of psychiatric nursing" are not defined so as to attempt to itemize and specifically delineate all those numerous things that a registered psychiatric nurse may do but, rather, to set out in broad terms the functions of a

psychiatric nurse in the health care system.

In my opinion, the legal limitations on registered psychiatric nurses are similar to those upon registered nurses and are as follows:

a) The functions undertaken by registered nurses must be consistent with the definition of "psychiatric nursing" or "the practice of psychiatric nursing". However, given the broad description of the functions a registered psychiatric nurse may carry out, there is considerable room for the profession to move into new or expanded roles.

b) If registered psychiatric nurses are held out as being able to perform certain functions, they must have the capacity and skill to perform them. As with registered nurses, whether such is the case will depend in large part upon their training and qualifications. Furthermore, it would be essential to the expansion of psychiatric nursing into new or expanded roles that proper educational standards and training be developed to ensure that the registered psychiatric nurses who are to practice in those roles will have the necessary skills and capacity. In that regard, I note that the regulation-making power contained in clauses 6(1)(c), (d) and (e) of The Registered Psychiatric Nurses Act are similar to those I have quoted from The Registered Nurses Act.

The Registered Psychiatric Nurses Act does not contain any prohibition upon registered psychiatric nurses carrying out any specific functions. Furthermore, the Act does not specifically require registered psychiatric nurses to be dependent upon or responsible to medical practitioners in carrying out their functions.

Legal Limitations on Licenced Practical Nurses:

Nurses "acting within the scope of ... The Licenced Practical Nurses Act" are exempt by virtue of subsection 2(2) of The Medical Act from the prohibition on persons practicing medicine without a licence contained in that Act.

By virtue of subsection 11(1) of The Licenced Practical Nurses Act, a person who is registered and whose name appears on the roster of active practicing members "is entitled to hold herself out as a licenced practical nurse without restriction, except for any restriction that may be imposed by any by-law of the association".

The scope of The Licenced Practical Nurses Act as described in the definition of "practical nursing" and "the practice of licenced practical nursing" in clause 1(i) is much narrower than the scope of The Registered Nurses Act and The Registered Psychiatric Nurses Act. The narrower scope reflects the fact that by virtue of the definition of those terms, licenced practical nurses are not allowed to practice independently but are specifically restricted to assisting "registered nurses in the care of acutely ill patients and rendering those services for which" they have been trained; undertaking "the care of patients under the direction of a medical practitioner or a registered nurse" and to administering "medication prescribed by a medical practitioner consistent" with their training.

The legal limitations on licenced practical nurses are, in my opinion, as follows:

a) Licenced practical nurses would have to practice within the limits set out by virtue of the definition of the terms "practical nursing" and "the practice of licenced practical nursing".

b) If licenced practical nurses are held out as being able to perform certain services, then they must have the capacity and skill to perform them. Once again, whether such is the case will largely depend upon their training and qualifications.

I hope this will be of some assistance to the Nursing Review Committee and I hope that the delay in providing you with this opinion has not caused any inconvenience.

Yours truly

T. G. Hague
Crown Counsel

McJannet, Weinberg, Riley, Adam

BARRISTERS AND SOLICITORS

JACK T. McJANNET, Q.C.
ALLAN H. ADAM
MURRAY M. KRAVETSKY
GEORGE J. ORLE
D. MICHAEL WILLCOCK
PETER SIM
MARGOT D. LANGDON

*ALSO A MEMBER OF THE SASKATCHEWAN BAR

A. LIONEL WEINBERG, Q.C.
ABE ANHANG *
EDWARD P. ZINMAN
DANA J. NEILO
DAVID M.R. CHEOP
CHRISTIAN MALBURG
ROBERT G. BRIERCLIFFE

WILLIAM P. RILEY, Q.C. *
ERNEST A. WEHRLE
MICHAEL D. WERIER
JEFFREY A. SCHNOOR
SYLVIA GUERTIN
MICHAEL FINLAYSON

FIFTH FLOOR
185 CARLTON STREET
WINNIPEG, MANITOBA
CANADA R3C 3J1

TELEPHONE (204) 942-8101

TELECOPIER (204) 942-8101
TELEX 075 7183

February 25, 1985

The Honourable
Mr. Justice Joseph F. O'Sullivan,
Chairman,
Nursing Review Committee,
206-1580 Dublin Avenue,
Winnipeg, Manitoba R3E 0L4.

Dear Sir:

Legal opinion: re registered nursing

You have forwarded to us a copy of a legal opinion dated October 22, 1984 from Mr. T. G. Hague, of the Department of the Attorney-General.

You have asked us to review only that portion of Mr. Hague's letter which relates to legal limitations on registered nurses. We have done so and find ourselves in substantial agreement with Mr. Hague.

In our opinion, registered nurses are limited in the scope of their practice in the definition of "nursing practice" and the "practice of nursing" as contained in clause 1(g) of the Registered Nurses Act. We agree also that the terms are so broadly defined that there is a vast amount of room for the profession of nursing to evolve, thus creating expanded or new roles for registered nurses.

However, we offer the opinion that it would have been better not to have a definition at all. We have read over with care the portion of the report of the 1977 Task Force on Nursing Education (pages attached) and agree with the opinions therein set out by Mr. J. F. Redgewell, then government counsel, and Mr. R. Brock, then counsel for the College of Physicians and Surgeons of Manitoba.

We agree with the opinion there expressed that every definition is necessarily delimiting and, in view of the very great freedom enjoyed by registered nurses to develop their profession without a definition, it is difficult to see what has been gained by including a definition. There arises no question in this Act of a legislated mandate or an exclusive right given to registered nurses to practice nursing, situations which would then have clearly required definitions. What has been achieved by these definitions, is that there is some restriction on registered nursing practice which was not there before and yet there has been achieved no mandate to set standards for nurses as opposed to registered nurses.

We agree further with Mr. Hague's opinion that, if registered nurses are held out as being able to perform certain functions they must have the capacity and skill to perform them.

We would not, however, say that this is a requirement for determining the scope of practice. Even though a medical doctor may be unprepared and inadequate and lacking in skill in law, he does not cease to be a medical doctor and have the right to practice medicine. His lack of skill may subject him to discipline and legal liability for negligence. It is not, however, the individual's skill or lack of skill which determines the scope of a profession. The existence of skills in a profession as a whole and the nature of preparation commonly given are both indicative of the scope of the profession, but not determative of it. Standards are established within the scope of nursing; the scope of nursing is not determined by the standards established within its scope.

In the course of our discussion on this matter, you have brought to our attention a letter from the College of Physicians and Surgeons of Manitoba dated April 5, 1984, enclosing a statement on medical and nursing responsibilities issued jointly by the College of Physicians and Surgeons of Manitoba and the Manitoba Association of Registered Nurses.

In our opinion, statements of this kind are potentially very restrictive of the scope of registered nursing. They are not simply statements of amicable understanding but may have considerable legal force.

When courts are faced with the task of deciding whether or not this role or that function is within the definition of nursing practice in The Registered Nurses Act they will have regard to a number of factors including the general opinion held by responsible leaders of the nursing profession as to what the scope of nursing practice is. Joint declarations of the above kind, being official, are likely to be regarded as highly significant. To the extent that such statements recognize an expanded role, they may indeed be helpful in establishing a broader scope for nursing. It is all too easy for such statements to be read in a restrictive sense so as to preserve for medical doctors an area of service which they do not have either by statute or by tradition, a tradition recognized as a living force subject to development and enhancement.

Just as in statutes, definitions and division of territory set out in such statements are potentially restrictive and delimiting.

This letter has been prepared by Mr. Christian Malburg of this firm, assistant secretary of St. Boniface General Hospital,

and one of the counsel of the Grey Nuns of Manitoba, and is concurred in by Mr. Ernest A. Wehrle, the solicitor for St. Boniface General Hospital and chief counsel for the Grey Nuns of Manitoba.

We thank you for giving us the opportunity to serve you.

Yours faithfully,

McJANNET, WEINBERG, RICH

Per: Christian Malburg

CHRISTIAN MALBURG

CM/sk

Excerpt from Report of the Joint Ministerial Task Force on Nursing Education in Manitoba, pp. 74-86, December 1977,

CHAPTER IX: A MECHANISM FOR CERTIFYING COMPETENCE IN POST-BASIC SPECIALTIES

Development of a process to recognize advanced competency in nursing practice is both desired and needed. The absence of a mechanism for certifying the competence of specialist nurses is, in the opinion of the Task Force, a major drawback in the development of an expanded role for nurses and in the adequate provision to the public of the care which nurses are giving and will be expected to give.

Ideally, such a certifying mechanism should be Canada-wide in scope. However, until such time as that mechanism is developed, the Task Force recommends that the Manitoba Association of Registered Nurses should itself undertake the task of certification. Only if the M.A.R.N. is unwilling to accept the challenges implicit in assuming the role of a certifying body should consideration be given to entrusting the role to some other group such as a body created by the legislature.

It is important to note that certification of competence is essentially distinct from registration. Registration has some of the characteristics of licensure. A person who is not registered as a Registered Nurse is not entitled to hold himself out as such and does not gain the rights accorded to a Registered Nurse under The Medical Act or a nurse practice act. The M.A.R.N. is responsible for establishing standards by which it decides whether or not to register or to continue the registration of practicing nurses. Until now, renewal of registration has been automatic with a payment of a registration fee. The Task Force is advised that M.A.R.N. has recognized that is not a desirable situation and is currently developing standards for continuing registration.

It would be possible to establish a specialist register and to require that those who hold themselves out as specialists should by law be required to be registered on the specialist register of a professional nursing association. At the present time the M.A.R.N. acknowledges that it does not have the authority to *require* persons claiming to practice as nurse specialists to meet specific education or practice requirements.

IX

There are many authorities who have pointed out the inherent dangers in such legal registration or licensure of specialists. H. K. Krever, for example, said:

> "When I say I do not favor 'licensing' of the physician's assistant, I do not mean that we can do without the creation of a mechanism for qualifying, regulating and certifying such person. To license a person is to confer on that person a monopoly of practice and to prohibit... any one not so licensed to engage in the practice which that licensed person is alone authorized by law to carry out... Whenever one licenses an occupational group one is faced squarely with the problem of defining the scope of practice... to limit or to place boundaries around... Yet we live in an era of change... Why resort to a means that is essentially static when we are concerned with a dynamic process? My point is that these (job) specifications ought not to be legislated into 'scope-of-practice' provisions of licensing."[47]

A specialist register of this kind would require amendment to the statute governing Registered Nurses. Since each province is a separate law country and subject to its own legislature, legislated provision for a specialist register might well prevent the development of countrywide certification.

No doubt considerations of these kinds have induced lawyers and physicians and surgeons and others from ever adopting the idea of having legislated specialist registers. That has not, however, prevented the medical profession from developing mechanisms of certification that have been powerful instruments toward the development of medical specialties and have upgraded the quality, status and position of medical and surgical practitioners.

Certification in the medical field is in the main given by the Royal College of Physicians and Surgeons of Canada which establishes the criteria by which it will recognize certain doctors as experts in a particular field. There is legally no prohibition against any doctor licensed to practice medicine from practicing any specialty he chooses. But in practice, few health care facilities will grant privileges in specialized fields of practice unless a physician or surgeon holds a recognized specialist certificate or is judged to have equivalent qualifications. The public is protected in a practical way; doctors receive

recognition and status; medical science and art is advanced.

In the opinion of the Task Force, there is nothing to prevent the development of similar specialist certification among nurses except the recognition of the ability of their organized nursing bodies to embark on it.

The lack of certification involves many disadvantages both to nurses and to the public. It is a fact that there are today many nurses practicing with a high degree of specialization who do not have any recognition outside of the institution or setting in which they practice. If they change jobs, there is no one other than the last employer to warrant their specialized skill and knowledge. From the employer's viewpoint, there is no one other than the previous employer to certify that a particular nurse has or has not got the skills and requirements to function in a job which is felt to require special skills and ability.

This problem is likely to achieve increasing significance with the widespread development of collective bargaining for nurses. There is a distinct tendency in such collective bargaining for special monetary allowances to be made for the attainment of academic degrees; because of the absence of a certifying mechanism it is difficult to identify those nurses who should be compensated by extra allowances in recognition of the special skills and abilities which they have acquired in a specialty.

In the opinion of the Task Force, it would not be desirable to see in nursing the kind of development which has evolved in the profession of teaching where the achievement of academic degrees is rewarded by extra remuneration without particular regard to whether or not such academic degrees are related to increased competence as a teacher. It may be that for teachers an academic degree in any subject enhances the ability of a teacher to teach even though the degree is in a course quite unrelated to what is being taught. The same cannot be said for nursing. Nursing specialties beyond the post-basic level require both academic and practical preparation directed to developing expertise in specific areas of practice.

The Task Force is aware of the reluctance of the Canadian Nurses Association to embark immediately on a program of certification of specialties. In its statement on specialization in nursing of October 1973, the Association recommends "recognition of degrees or levels of specialization within

the profession". However, it stops short of proposing that professional associations undertake the responsibility of certifying such specialization. It says:

> "It is the responsibility of the professional associations to evaluate the need for specialized nurses, to interpret their functions to allied professions and agencies both governmental and private, to assist the specialization process to develop in an orderly manner and to develop norms of competence."[48]

The C.N.A. position paper says that:

> "regulation should be assumed by the nursing profession once research has determined the proper procedure. Until then, the C.N.A. will undertake the preparation of voluntary temporary standards which would determine the requirements for the appellation of specialized nurses. C.N.A. supports the establishment of a group or society of specialized nurses and agrees with the principle of formal liaison between this group and C.N.A."[49]

It is assumed that the Canadian Nurses Association means by "regulation" - "regulation of certification". If so, it appears that organized nursing as a whole is deeply conscious of the need for certification and ready to assume eventual responsibility for it. It is not clear how the recent surrender of authority to an Ontario Nursing College will affect the ability of Canadian Registered Nurses to act.

The Task Force recommends that the M.A.R.N. should, in the meantime, assume responsibility for issuing certificates of competence in those specialties which it identifies as suitable for such certification.

In the opinion of the Task Force, there is nothing in law to prevent such certification from proceeding now. Indeed, a strong case can be made for saying that the issuing of certificates will strengthen the rights and responsibilities of those who obtain from the M.A.R.N. a specialist certification.

In discussing certification as an aid to the development of nurse specialists, it is important to keep in mind the different developments in nursing law as between the United States and Manitoba. So many of the ideas that become current among nursing leaders originate in the U.S.A. that

there is always a danger that the ideas will be accepted here without the necessary adaptations because of our different systems.

In the United States, mandatory practice acts have become common since the first one was adopted in New York in 1938 which prohibit "nursing" as defined in the acts without a license. Bonnie Bullough, R.N., Ph.D. describes the process in her article, "The Law and the Expanding Nursing Role":

> "Besides being linked with the stratification of the nursing role, mandatory licensure included another interesting implication. In order to pass a mandatory act of any kind, it was necessary to spell out the scope of practice of the occupation which was being protected against encroachment. The older nursing laws merely made it illegal for an unauthorized person to use the title 'registered nurse' but it was not illegal for such a person to practice nursing. Once the new mandatory laws made it illegal for an unauthorized person to practice nursing, a definition of the scope of practice had to be written into these laws, so that violations of the mandatory provisions could be identified. Eventually the definition even came to be thought of as a goal in and of itself. Nurses and the legal advisors of the day advocated that the scope of practice be defined in nurse practice acts.
>
> The process of defining nursing and passing mandatory nurse practice acts was facilitated in 1955 when the Board of Directors of the American Nurses' Association (ANA) adopted a model definition of nursing. Professional practice was defined as:
>
> > '... the performance, for compensation, of any acts in the observation, care and counsel of the ill, injured or inform or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatment as prescribed by a licensed physician or a licensed dentist, requiring substantial specialized judgment and of biological, physical and social science. The foregoing shall not be deemed to include any acts of diagnosis or prescription of therapeutic or corrective measures.'
>
> This definition became the new model for changing nurse practice acts, so that, by 1967, 15 states had incorporated the language of this model into their state laws, and six states had used the model with only slight modifications. A notable aspect of this model act, as well as the other similar definitions of practice, is the disclaimer which clearly spells out the fact that nursing did not include any acts of diagnosis or

> the prescription of therapeutic measures. Before the era of mandatory licensure, nurse registration acts did not define nursing, with the result that they did not include any such disclaimer. Moreover, some of the definitions passed before the ANA model act was formulated used other language which did not forbid diagnosis and treatment.
>
> Actually, by 1955, when the model act was issued by the ANA, nurses were a fairly well-educated group of workers. (She describes the high standards developed in nursing schools). With this educational background nurses were, in 1955, observing patients, collecting data about their conditions, and acting on those decisions to deliver nursing care. They were in short, making diagnosis and therapeutic decisions, and the disclaimers in the scope of practice statements which were enacted in this period were out of date at the time they were written.[50]

When efforts began to develop an expanded and extended role for nursing in the U.S.A., it was necessary to devise various coping mechanisms to attempt to deal with the restrictions in the nursing acts and in some medical practice acts which also contained similar restrictions. These coping mechanisms are described in detail by Bullough. They have included attempts to work out joint statements with organized medicine (not too happily), lobbying (often successful) for amendments to the nursing practice acts, and attacks on the "medical model" of health care.

In Manitoba, however, the same kinds of coping mechanisms are not necessary since Manitoba has never adopted mandatory practice legislation for nursing. Moreover, in this connection, it is important to recognize that medical practice acts differ from jurisdiction to jurisdiction. What may involve a risk of "running afoul of the medical act" in one of the United States does not necessarily involve such risk in Manitoba. The simple fact of the state of legislation in Manitoba is that Registered Nurses obtain the legal right to practice the healing arts, not from the statute governing their association so much as from The Medical Act itself. That Act prohibits ordinary citizens from practicing the healing arts but expressly exempts from such prohibition those who practice the calling of nursing within the scope of The Registered Nurses Act, The Psychiatric Nurses Training Act and The Licensed Practical Nurses Act. It is not the statute law that sets boundaries to the role of nurses in Manitoba but the principle that no one may prudently practice without having the skills and abilities that they hold themselves out as having.

There is bound to be controversy as to when nursing passes over into medicine, but the solution is not best found in setting up regulatory bodies outside the professions. When such questions arise it is to be expected that the courts here will be sympathetic to the idea that what constitutes the calling of nursing within the scope of the nursing acts must be interpreted according to the concept of an expanded and extended role for nursing. The courts are not likely to be unduly restrictive of nursing practice in particular cases and it is only particular cases that come before courts. On the other hand, attempts to delineate practice boundaries by statute are likely to provoke confrontation with medical doctors and may indeed lead to unsuitable restrictions being imposed on the practice of nursing.

Registered Nurses themselves should set standards of practice in specialist areas and, having determined the criteria by which certification will be given, organized nursing should back up its specialist practitioners with appropriate certificates of competence. As in the case of medical specialist certification, nursing certificates of special competence will in themselves have no binding effect at law, but as employers of nurses and patients as a whole gain confidence in the certificates there cannot help but be immense benefits both to the nursing profession and to the public. Furthermore, such certificates and the standards on which they are based are likely to be recognized by the courts as cogent evidence of what is included in the calling of nursing within the scope of The Registered Nurses Act.

The Task Force's view as to the possibility of developing expanded roles for nurses without amendment to either The Registered Nurses Act or The Medical Act is confirmed by a legal opinion given on April 14, 1974, by Mr. J. F. Redgwell, Legal Consultant to the Department of Health and Social Development. Mr. Redgwell said:

> "There is nothing in law to prevent either expanded training for or the use of the designation 'nurse practitioner'. Such is entirely within the present scope of The Registered Nurses Act."[51]

It is further confirmed by an opinion given by Mr. Rees Brock of the Thompson Dorfman Sweatman firm on September 14, 1974, to the Registrar of the College of Physicians and Surgeons of Manitoba. His opinion reads in part:

> "The Registered Nurses Act of Manitoba... does not define nursing. Under Section 10, however, in order to qualify and be eligible for membership in the association, a person must successfully complete a course of nursing in Manitoba approved by the accrediting committee.
>
> Under Section 11, a curriculum of studies and program of training in any school of nursing in Manitoba may be prescribed by the Board.
>
> Under The Medical Act... a nurse practicing within the scope of The Registered Nurses Act, The Psychiatric Nurses Training Act, or The Licensed Practical Nurses Act, is exempted from the definition of 'practice of medicine.'
>
> I entirely agree with you that this does not mean that a nurse may do anything she wants and not be considered as practicing medicine. She would only be entitled to do those things for which she is trained and qualified and which follow generally accepted principles within her profession as to what constitutes the practice of nursing. In order to establish these criteria, one would normally fall back on the training program in the school of nursing prevalent at the time and the custom of the profession."[52]

That there will be some dynamic tension with other professions is obvious. On May 11, 1974, the Council of the College of Physicians and Surgeons of Manitoba approved a resolution which would seriously limit any expanding role by nurses, if adopted by society as a whole. It read:

> "That when para-medical personnel undertake functions which form a part of the practice of medicine, they should have appropriate training and should be professionally responsible for these medical duties to a duly qualified medical practitioner."[53]

The prospect of tension was further confirmed before this Task Force by the brief presented to it by the Manitoba Medical Association. That Association purported to welcome the development of nurse practitioners but wanted it to be made clear that such nurse practitioners must not "diagnose". The Task Force is of the view that it is a false dichotomy to assign diagnosis to medicine and something short of diagnosis to nursing. There is no warrant in general law, practice or good sense to limit diagnosis in this way. Every good nurse and every employer of nurses knows that nurses are involved in diagnosis every day they work.

If doctor's orders are primary in most health care facilities, that is not in Manitoba a requirement of the law or of the "system". The primacy of doctor's orders arises from the fact that patients in general entrust their care to a physician rather than to a nurse. In hospitals, it is that fact, together with the requirements of by-laws, that establish the hierarchical nature of doctor's orders which must be followed loyally by nurses.

But where nurses function as independent primary care givers, for example, in a remote northern station, they must make independent decisions regularly. It is idle to pretend that they are following doctor's orders, or a medical protocol, when they diagnose a patient to determine whether or not to call a plane to have the patient removed to a hospital.

The question of nurse practitioners is dealt with further under the heading, "Questions for the Future". But the evidence is overwhelming that there is a serious need for an expansion of the number of nurses practicing as such primary care givers, and that not only in the North and in isolated areas but in major cities like Winnipeg where access to health care is broad in theory but limited in practice.

Certification by organized professional nursing can go a long way to gaining acceptance of this expanded role for nurses. There is no doubt that certification involves the assumption of a very large responsibility. The effectiveness of certification depends on the confidence of those who employ nurses who are certified. The very voluntary nature of certification means that organized nursing cannot proceed in isolation to determine the numbers needed or the skills called for. There must be meaningful consultation with employers of health workers and with the public. The means of consultation with employers in Manitoba is already well established. The Manitoba Health Organizations Inc. embraces practically all of them outside government and has a good working relationship with its members. If the recommendation of this Task Force for a Commission of Nursing Education, with adequate staffing, is adopted, then there will be a ready means of consultation with a citizen body charged to look out for the interest of the recipients of nursing care, to monitor the types and numbers of nurse specialists required and to provide funding for training and preparation.

Furthermore, assumption of the task of certification implies that the determination of criteria for specialist practice will be in the hands of

clinical practitioners rather than exclusively with nurse educators. The very act of determining criteria or standards for a particular specialty itself creates the model and the objectives toward which nurse educators must design curricula and content.

If organized Registered Nurses take on responsibility for certifying specialists, there will needless to say have to be a measure of flexibility in outlook and in practice. Any attempt to make a master's degree a pre-condition of all specialist certification, at the present time in Manitoba, would of course be doomed to failure. It is important that specialist certification should be realistic and that, at least in the early stages of the process, certification should not be limited to graduates of academic programs but should be open to nurses with equivalent practice and experience. However, it is essential for some individuals to pursue specialization via the master's route to have the depth of knowledge required to teach. It would be a grave error to overlook the existence now of specialists who have every qualification except recognition.

At the same time, the Task Force would caution that it would be counter-productive to attempt to certify too many nurse specialists at once. The whole concept of certification by a professional body of nurses is a new one in practice; it should be approached with care. It would seem, however, that it is vital for the certifying body to begin soon to certify nurse practitioners who can function on their own without requiring doctor's orders. The Task Force recognizes that there is a tendency to feel that such nurse practitioners should be limited to nurses with baccalaureate degrees, but cautions that the reality of life in Manitoba is that the immediate needs in the province today are for nurse practitioners in northern, rural and isolated communities, that it is difficult to have degree nurses move to such settlements and that diploma nurses with post-basic training have in fact proved that they can function adequately as nurse practitioners since they are doing so successfully today, without any professional certification.

A factor that must be weighed in determining the appropriate body to act as the certification agency is the current division of nursing in Manitoba. The M.A.R.N. has jurisdiction to certify only Registered Nurses and that leaves outside the scope of M.A.R.N., certification of nurses who practice as Licensed Practical Nurses and as Registered Psychiatric Nurses.

It is evident that parallel development of three kinds of advanced competencies might result in duplication and discrimination with a waste of educational facilities and misuse of nursing and other manpower.

One solution to this problem for Manitoba might be to have a joint certifying committee of the three associations. However, considering that country-wide certification of specialist professional nurses is the only ideal situation, it would be retrogressive to create a special kind of certifying body in Manitoba that could not easily be adapted to the eventual assumption of responsibility for certification either by the Canadian Nurses' Association of Canada acting in concert or by the creation of a certifying body akin to the Royal College of Physicians and Surgeons, and the College of Family Practice of Canada.

The Task Force is of the opinion that only the Manitoba Association for Registered Nurses should issue certificates of special competence at the present time.

The Task Force recommends that there should be no attempt to establish certification for specialist L.P.N.s. It is entirely desirable that there should be developed regularly offered enrichment courses and continuing education either on a full or part-time basis at the community colleges. While it has been noted that the newly licensed practical nurses are able to demonstrate technical competence in their role, continuing education in the form of post basic courses, should be offered to enable L.P.N.s to keep abreast of the changing health care scene. Only through continuous efforts to keep pace with progress in areas such as Geriatrics, Home Care Services, Ostomy Care, etc., can practical nurses keep pace with new nursing techniques and give more comprehensive patient care.

One of the urgent tasks of the organized bodies of nursing in Manitoba, as well as of the Commission of Nursing Education, is to devise methods by which such upward career mobility can be enhanced and developed without turning the entire Licensed Practical Nurse category into one that is regarded by themselves and the public as "second class" or as mini-R.N.s.

The Task Force has come to the conclusion that, for the reasons given in an earlier section of this report, it would not be desirable to discontinue the category of Registered Psychiatric Nurses. Evidence

IX

presented before the Task Force makes a convincing case for the need to have some measure of post-basic training for Registered Psychiatric Nurses. However, we would caution against any formal certifying responsibility being assumed by the R.P.N.A.M.

Care must be taken that no barriers are erected to prevent the evolution of a comprehensive unity in nursing, where all professional nurses are linked whether they are engaged in the care of the body or of the mind or both.

This is particularly important as mental health care moves outside mental hospitals into general hospitals and into the community. There is a great deal of difference of opinion at the present time as to the appropriate place of Registered Psychiatric Nurses in the new occupation of community mental health workers. In geriatrics, there is a growing need for nurses who have skills and aptitudes for psycho-geriatrics and it is by no means clear at the present time whether such nurses should most appropriately be drawn from the ranks of Registered Nurses or of Registered Psychiatric Nurses.

The Task Force does not seek to diminish the development of post-basic courses for Registered Psychiatric Nurses; it will be seen in a later section of this report that in fact the Task Force favours the development of a University school embracing Registered Psychiatric Nurses at Brandon. No doubt a convincing case may in the future be made out to the Commission of Nursing Education to induce that Commission to fund and support a number of post-basic education programs.

Yet the Task Force suggests that the Registered Psychiatric Nurses group should not attempt to establish a certifying mechanism. Continuous attempts should be made at the specialist levels to bring about a fusion between Psychiatric and Registered Nurses. It is imperative that mobility between one group and the other should be increased through mutual recognition of common courses and credits. Certification by the M.A.R.N. could play an important part if criteria for certification in some specialties included an acknowledgement of past training obtained as an R.P.N.

In a parallel situation, a statement by J. P. Lysaught has relevance for Manitoba:

"The specifics of the arrangements can be worked out in the crucible of experience but the general proposition of closer relationships is one that... is essential. The combined activity of the statewide groups in educational planning and joint practice should produce impetus from both ends towards reconstruction of a strongly based middle ground... Only then will the two arms of professional nursing be rejoined in a common mission."[54]

APPENDIX V

JOINT STATEMENT ON MEDICAL/NURSING RESPONSIBILITIES ISSUED BY THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA AND THE MANITOBA ASSOCIATION OF REGISTERED NURSES

THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
1410-155 Carlton Street
WINNIPEG, Manitoba R3C 3H8
Telephone (204) 947-1694

Address all correspondence to
the Registrar

April 5, 1984

Mr. Justice O'Sullivan, Chairman
Manitoba Nursing Review Committee
206-1580 Dublin Avenue
Winnipeg, Manitoba R3E 0L4

Mr. Justice:

Your letter of March 2nd, 1984 was of interest to the College because of the important working relationship which exists between physicians and nurses. As a result of this relationship the College has attempted to develop improved and more frequent communication with the Manitoba Association of Registered Nurses and has worked with the MARN to draft the document "Medical/Nursing Responsibilities", a copy of which is attached.

The Executive Committee has considered that although most doctors would have an interest in the deliberations and conclusions of your committee, the College's role was primarily the regulation of medical practice, and the views of the profession on other community interests were more appropriately presented by the Manitoba Medical Association. Although we are not submitting a brief we would be pleased to respond to any questions which arise which our committee feels may impact on the practice of medicine as defined in the Manitoba Medical Act.

Thank you for inviting the College to present a written submission to your committee. We will continue to follow your important work with interest.

Yours sincerely,

JAMES B. MORISON, M.D.
Registrar

JBM:mm
Enclosure

cc: Manitoba Medical Association

NURSCENE: Vol 8, Number 2, March-April 1983

STATEMENT ON MEDICAL/NURSING RESPONSIBILITIES

Issued jointly by:
The College of Physicians and Surgeons of Manitoba
Manitoba Association of Registered Nurses

Preamble

The purpose of this statement is to provide a general guide in the establishment of practice policy. It is recognized that situations will vary according to size, geographical location and nature of health agency, as well as in the availability and preparation of health personnel.

The responsibilities of the members of the health team are determined by their educational preparation in terms of the knowledge, judgment, and skills required to provide safe and efficient treatment to individuals and families.

This document has been written to differentiate the functions of medicine and nursing by the clinical responsibilities for which they are accountable, rather than specification of the infinite array of tasks they could complete.

The clinical responsibilities defined reflect those areas of educational preparation which are common and unique to medicine and nursing and have been labelled accordingly.

MEDICAL/NURSING RESPONSIBILITIES

Responsibilities of the Physician

The following functions must be carried out by the physician responsible unless delegated with supervision to another health professional.

1. Definition of the specific nature of a medical illness and its underlying pathophysiology.
2. Identification of the urgency of the medical condition and pace of medical evaluation.
3. Identification of the appropriate diagnostic procedures and laboratory investigation.
4. Prescription of the appropriate medical treatment.

Shared Responsibilities

In appropriate circumstances these responsibilities may be carried out by the physician, the nurse, or conjointly depending on the nature, number or complexity of identified problems.

1. Individual/family health assessment (history, examination).
2. Identification of life-threatening conditions.
3. Individual/family health management decisions.
4. Individual/family health management.
5. Documentation of health care.
6. Communication (with individual/family, involved health professionals, community).
7. Individual/family health education.
8. Health professional student education.
9. Supervision of health personnel.

Responsibilities of the Nurse

The following functions either may be carried out by the nurse responsible or delegated with supervision to another health professional.

1. Coordination of individual/family health management.
2. Identification of health problem perceived by individual/family.
3. Facilitation of individual/family's contact within the health system.
4. Identification and management of unmet physical needs.
5. Identification and management of limitations to health restoration/adaptation.
6. Individual/family counselling re: preventative health practices, adaptation to illness/disability, resolution of situational/developmental crises.
7. Implementing care relevant to medical treatment.

April 1983.

APPENDIX VI

HIGHLIGHTS OF THE MANITOBA ASSOCIATION OF REGISTERED NURSES' ENTRY TO PRACTICE REPORT

Background:

The Canadian Nurses' Association has resolved that by the year 2000, the minimal educational requirement for entry into the practice of nursing should be successful completion of a baccalaureate degree in nursing. The C.N.A. states nurses will need enriched education because of:

- ongoing advances in the physical, biological and social sciences
- technological developments, especially those associated with biomedical engineering
- an anticipated increase in community-based services with the nurse or nurse practitioner becoming the point of entry to the health care system
- communication at the same level as other professionals.

Most of the provincial nursing associations have endorsed the C.N.A. position.

The Manitoba Association of Registered Nurses has taken a different approach to the entry to practice issue than other provincial associations. Rather than voting on the resolution from the Canadian Nurses Association, the Manitoba Association of Registered Nurses established an ad hoc committee on the Entry to Practice issue. This committee, in January, 1982, undertook a three-year research project to define the minimum competencies that future nurses should possess. The educational requirements for a future basic nursing program were based on these defined competencies. It was not assumed (at the project's outset) that the educational program would be a university-based baccalaureate degree program.

Highlights of the M.A.R.N. Entry to Practice Report:

Entrance to practice is defined as the educational preparation required to commence practice as a registered nurse. Future was defined as 1992, but as implementation by this date did not appear feasible, it was changed to 2000.

One hundred and seventy-two competencies (for future nursing graduates) were identified through literature and criterion group review and were content --- validated through a survey of 1,123 active practicing Manitoba Association of Registered Nurses members. These competencies reflect the view that knowledge of both technical and psychosocial aspects of care is becoming increasingly necessary for registered nurses.

A working group of nurses and health educators worked with the Entry to Practice Committee in defining the educational pre-requisites for the future competencies identified by the membership.

Recommendations of the M.A.R.N. Entry to Practice Report:

The major recommendations of the report are that the future basic program should:

- Prepare the new graduate to demonstrate the defined competencies through the provision of a generalist professional core and the acquisition of knowledge, skills and experiences required for competency development within one of several clinical practice majors such as maternal-child, mental health, primary care/rural generalist, restorative/rehabilitative, gerontological (length of preparation time is estimated at 2-3 years for the generalist professional core; 1-2 years for each of the clinical nursing practice areas; 2-2½ years for the relevant basic/social sciences and humanities.)

- Be university-based with learning occurring in multiple settings and teaching centres. (The report indicates that the credential, diploma/degree, granted to the graduate is not the main issue. However, as the program will be 4 to 6 years in a post-secondary educational program, it is suggested that a degree be granted.)

- Include strategies for accessibility and flexibility (e.g. provision of portable nursing education courses for regions, necessary support services, etc.)

- Be funded and administered by Manitoba Education.

In regard to registration concerns, it is indicated that since the future new graduate will be certified to demonstrate the expected competencies within one of several defined clinical practice majors, the registration certificate should indicate the contexts of nursing practice in which competence to practice has been certified. The status of registered nurses currently registered to practice would not change. However, it is recommended that all nurses registered through the present process be given twenty years (until

2020) to apply for certification of competence and registration in a clinical nursing practice major.

The 23 recommendations of the Entry to Practice Report were accepted by the Manitoba Association of Registered Nurses' membership in April, 1984.

Reference: Manitoba Association of Registered Nurses, Entry to Practice Report; February 1984.